HC-One Oval Limited

Mornington Hall Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service:
Mornington Hall Care Home is a large care home for people living with dementia some of whom also have nursing care needs. It is divided into four communities for 30 people each. Two of the communities are for people with nursing needs, and two are for people living with dementia. At the time of our inspection 108 people were living in the home.

People's experience of using this service:
People living in the home had varied experiences of care. While some people told us they felt safe and well cared for, others told us they were bored and staff were slow to respond to their requests for support. During the inspection we saw people were not always treated with kindness and compassion.

Risks to people living in the home had not always been mitigated and care plans lacked details about people's needs and preferences. Information within files was sometimes contradictory and this put people at risk of harm.

Information about people's ability to made decisions and choices was not clear. It was not clear that staff were following the principles of the Mental Capacity Act 2005.

Staff were deployed according to people's level of need, and had been recruited in a way that ensured they were suitable to work in a care setting.

The service had identified many of the issues we found with the quality and safety of the service. However, the actions in place to address these issues had not yet been effective.

There were lots of different ways for people to provide feedback about their experiences.

Some areas of the home had been redecorated to make them more suitable for people living with dementia. However, it seemed these resources were being under-used.

Rating at last inspection:
The service was rated Good overall and in each of the key questions when it was last inspected in July 2017.

Why we inspected:

This inspection was brought forward as we received information from local authorities and members of the public that indicated the quality and safety of care at Mornington Hall Care Home may have deteriorated.

Enforcement:
We identified breaches of six regulations. These related to person centred care, dignity and respect, need for

consent, safe care and treatment, staffing and good governance.

Please see the end of the report for details of our regulatory response.

Follow up:

We will continue to monitor the service closely and liaise with commissioners to monitor progress. We will return to inspect the service in line with our public commitments.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our Well Led findings below.

Mornington Hall Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notifications and feedback from commissioning local authorities which indicated the service may not be appropriately responding to changes in people's needs or escalating concerns to the appropriate authorities. We had also received complaints from members of the public that suggested an elevated level of risk in the service.

Inspection team:
The inspection was completed by two inspectors, two assistant inspectors, an inspection manager, a directorate support coordinator and two experts-by-experience. An expert-by-experience is someone with personal experience of using, or caring for someone who uses services.

Service and service type:
Mornington Hall Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, both were looked at during this inspection.

Mornington Hall Care Home accommodates up to 120 people across four adapted buildings referred to as communities. Two of the communities specialise in supporting people with nursing needs and two specialise in supporting people living with dementia.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced.

What we did:
Before the inspection we reviewed the information we held about the service in the form of notifications submitted to us. Notifications are information about events that providers are required to tell us about by law. We also requested feedback from commissioning local authorities and safeguarding adults teams. We reviewed the feedback we had received from members of the public.

During the inspection we spoke with 12 people who lived in the home and five of their visitors. We spoke with two visiting healthcare professionals. We spoke with 15 members of staff including the Registered Manager, the regional quality manager, the deputy manager, the clinical lead, the chef, two domestic staff, two nurses, an activities coordinator and five care workers. We made observations of care throughout the day.

We reviewed 11 people's care files including needs assessments, care plans and records of care. We reviewed the medicines records for nine people. We reviewed the recruitment records for eight staff and the supervision records for a further five. We reviewed training information. We looked at various meeting minutes, incident records, complaint investigations, audits and other policies and records relevant to the management of the service.

After the inspection the provider submitted further audit records, action plans and information as requested during the inspection.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Health and safety checks were undertaken on each community. Community managers took the lead on daily and weekly checks of the environment and fire safety. In most cases fire checks were up to date but on one community there had not been a weekly check of fire doors for two weeks.

● The environment was not always safe. On three communities we found storage rooms unlocked which contained items such as linen, batteries and tiling grout. On one community a store room was filled with wheelchairs with the door propped open. This heightened the risk of fire doors being ineffective in the event of a fire. However, where rooms contained potentially harmful materials such as medicines, sluice rooms and cleaning products, we found that these were locked.

● Care files contained various assessments regarding the risks people faced in their day to day lives. For example, each person's risk of choking, developing pressure wounds and falling was assessed and reviewed monthly. However, there was conflicting information about the levels of risk and the actions taken to mitigate risks were not always clear. For example, one person living in the home had a pressure wound. We saw they had specialist equipment in place but this was not mentioned in their care plan. This person was described as being 'aggressive' on occasions but there was no information or guidance for staff within the file about how to mitigate the risks of aggressive behaviour.

●Risks associated with behaviour were not well mitigated and the guidance for staff was insufficient. Another person's care file contained a 'distressed reaction plan' which contained detailed descriptions of the behaviours. However, the "care and support to resolve" section contained a repetition of the behaviours and then advised staff to, "Try for chatting once she calm down." There was no direction about how to help them to become calm.

●Other risk assessments were inconsistent and unclear. For example, one person's choking risk assessment identified them as being at medium risk of choking. Their diet and nutrition plan referred to 'thick puree' but this was not mentioned in their choking plan.

●People had individual evacuation plans within their care plans, but these only considered their physical needs regarding emergency evacuations. They did not consider the impact people's cognition or dementia may have on their ability to understand and cooperate with an emergency evacuation of the building.

Using medicines safely

● People's medicines were not always managed safely. People's medicines care plans did not contain accurate lists of their medicines and lacked detail about how they wished to take their medicines.

● People's medicine administration records (MARs) contained multiple gaps and did not reflect best practice. In particular, where people received medicines on an 'as required' basis, staff had not documented when medicines had been offered and not required.

● We also found regular medicines were not always being recorded as administered accurately on the MARs. For example, one person was prescribed an inhaler and the MAR did not show that this had been administered the day before our visit. Another person was prescribed a cream to be applied daily and there was no topical medicine administration record (TMAR) in place to document this was being administered as prescribed, despite staff telling us they had administered this for the last 2 days.
● Concerns with people's medicines were not always identified and fed back to prescribing healthcare professionals. One person was prescribed a medicine that needed to be administered early in the morning before breakfast. The person's daily notes showed they frequently stayed up all night and were often given food in the morning by staff. On the day of our visit, they had not been administered this medicine by 10:30 despite the MAR saying it was required at 07:00. We saw evidence of the person's sleeping pattern having been discussed with the GP, but there was no record of this medicine having been discussed despite it not being administered in line with the prescriber's guidance.
● Another person had a regular injection from a visiting healthcare professional. Records related to this were not clear as some were recorded within healthcare professional records but the most recent was documented within daily notes. This injection was included on the MAR but the records were not kept in a manner that made it easy to monitor.
● Whilst we observed medicines were stored securely with regular environment checks, we identified times where best practice was not followed. On one community, the medicines trolley contained a pill crusher which had powder residue of medicines on it. Staff told us no one on this community required crushed medicine so it was not clear how long this device had been contaminated without staff identifying it.

Preventing and controlling infection
● The risk of the spread of infection was not safely managed. A community for people living with dementia smelt strongly of urine in communal areas throughout the day. An infection control audit dated November 2018 had identified this which showed this had been like this for over three months. We also found a dining chair in this community with old chewing gum stuck underneath the arm rest.
● The home environment was not always clean. In the morning, one toilet was left with faeces in the bowl and on the floor for 45 minutes and was only cleaned when we raised it with staff. We also found a toilet in this community with the cistern open with no lid, exposing the water and flush mechanism.
● Sluice rooms had strong unpleasant odours and were used as storage spaces. In one community, we found a variety of sundries and equipment stored in the room, including a cushion. Another community had a sluice that was also very cluttered and another contained two discoloured urine bottles. This heightened the risk that these items could become contaminated and spread infection.
● There was evidence that staff were not always maintaining appropriate hand hygiene. The basin in one sluice room was dry with discolouration that showed it had not been recently used. This showed staff were not washing their hands after using the sluice room. We also found a basin that did not appear to have been recently used in the medicines room of another community .

The above issues regarding risk assessments, medicines management and infection control are a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

● In other instances, best practice had been followed in relation to medicines. We saw accurate records were maintained around controlled drugs and these were stored in line with best practice. Where people were prescribed anticoagulants, staff maintained accurate records of dosages based on people's blood test results.
● Staff were observed following best practice when they administered medicines. Staff checked people's identities and checked which tablets they were dispensing against the MAR. Where one person was living with dementia, we observed a staff member taking a patient approach and explaining to them which

medicines they were taking and what they were for.

Staffing and recruitment

● Rotas showed that the provider's calculated staffing levels were being met. However, there was regular use of agency staff.

● People's dependency levels were assessed and this was reviewed monthly. People were assessed as having low, medium or high levels of dependency and the totals were used to calculate the staffing needs in each community. We noted that on one of the communities two people were incorrectly recorded as having low needs when their scores indicated medium. We also noted that the staffing calculation did not consider the impact of many people approaching the threshold between dependency bandings. In another community seven people were within 3 points of the threshold of being in a higher dependency band.

● People told us they sometimes had to wait for staff, and they did not feel there were enough staff available to them. Comments included, "Sometimes they have to stretch it [staffing] a bit." And, "There are not always enough staff." One person said, "The staffing is ok except toileting. They never come in time."

● We observed instances where staff were not effectively deployed to meet people's. In the morning on the community for people living with dementia, 15 people were in a room with 3 staff. One staff was administering medicines and another was serving breakfast. This left one staff member to provide interaction and engagement with 15 people. We noted that five people were falling asleep in their chairs and there were no staff available to interact with them. Later in the day, we observed one person alone in a corridor trying to get through a locked door with no staff supervision.

● Records of accidents and incidents showed that 10 people had been found on the floor in the last two months and a further two people had sustained injuries that had not been observed by staff. This reflected the lack of supervision and staff oversight we found during the inspection.

● Recruitment records showed the service had followed safe recruitment processes and ensured staff were suitable to work in a care setting. Where staff were registered healthcare professionals the service ensured their registrations were up to date.

Systems and processes to safeguard people from the risk of abuse

● Staff were able to identify the different types of abuse people may be vulnerable to and knew what the reporting processes were.

● However, a care worker described feeling uncomfortable raising issues about their colleagues. They told us, "Some people [staff] can be a bit brash but it is difficult to raise it as I don't want to make them angry."

● Despite previous concerns raised by the local authority we found the provider was raising allegations of abuse with the appropriate authorities. However, we noted the appendix to the safeguarding policy did not contain the local contact details which meant there was a risk that less experience staff may not be able to raise safeguarding alerts easily.

Learning lessons when things go wrong

● Records of accidents and incidents were monitored by the provider and records showed individual actions were identified in response to falls and incidents. The two most recent incidents were for two people who were found on the floor by staff. This showed that whilst the incidents were monitored, they had not prompted changes to staff deployment to increase supervision for these people .

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI:The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance
The mental The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- The service was not following best practice with regards to the application of the MCA. None of the care files reviewed contained any assessments of capacity for specific decisions. Although DoLS applications had been made it was not clear how the decision had been made that the person lacked capacity regarding restrictions or supervisions in place.
- Care plans frequently described people as having fluctuating capacity, or as being occasionally 'confused.' They did not contain any guidance for staff about the circumstances which might facilitate people to make their own decisions.
- Consent forms were unsigned or signed by relatives in care files. Within one file there was a copy of a lasting power of attorney authorisation. This related to property and finances and did not authorise the attorney to make decisions about health and welfare. The home maintained a document regarding whether or not people had appointed attorneys or deputies to make decisions on their behalf. This document was not fit for purpose as it did not describe the nature of decisions people were authorised to make, and was not clear if the legal authorisations had been confirmed.

The above issues are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- People told us they thought staff had the skills needed to provide their care.
- Staff told us they received training which they found useful.

●Training records showed not all staff were up to date with the courses required by the provider. Only 63% of staff had in-date training for moving and handling people, and completion rates for all other courses were below 90%. We asked for a detailed breakdown so we could see the role of staff who had not completed training. This showed 35% of care workers did not have in date training for moving and handling people. It also showed that only one nurse had completed training in care planning, dignity, the MCA and DoLS. This was reflected in our findings regarding the quality of care planning and other observations during the inspection.
●Supervision records were not available for staff from two of the communities during the inspection as they were held by the community managers who were not at work on the day of the inspection. We asked for these to be sent to us. The records submitted showed staff received identical supervisions which detailed their roles and responsibilities. Two of the records were completed after our inspection. The records did not consistently show staff received supervision and support required to perform their roles.

The above issues regarding training and supervision are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Staff completed a range of assessments before people moved into the home. These were used to create an introductory care plan which was meant to be updated into the full care plan as staff got to know people over their first few weeks living in the home.
●Assessments reviewed lacked detail and did not consistently reflect people's abilities and choices. For example, while one person's care plan identified they required support with various aspects of daily care, the support was only described as "assist" with each task. There were no further details to explain what assistance meant.
●Other assessments lacked detail regarding people's health and care needs. For example, one person's hospital discharge notes showed they had a life limiting diagnosis but the impact of this was not referred to in their care plan. Another assessment was inconsistent with the resulting care plan; the falls assessment stated there was no risk but the person was noted as requiring a mobility aid for walking.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they liked their meals and we saw most people were offered a choice for their main meal.
●However, we also saw people were not offered meaningful choices for other meals. For example, one person had misunderstood the options available and was brought a plate of food which bore no relation to the food he had requested. Staff apologised but were unable to supply the food he preferred.
●Staff were knowledgeable about the range of different religious and cultural diets people preferred within the home. The chef explained how they have a day a week where they prepare meals based on a particular culture's cuisine. They also had a list of people's birthdays and prepared cakes for people's birthdays.
●However, not everyone experienced a pleasant dining experience. We saw people who required support to eat their meals had to wait until other people had been served. This meant staff had to reheat their meals as they had got cold while they were waiting.
●People's files contained a diet information sheet which contained a high level summary of their dietary needs and preferences. However, it was not possible to tell from the records whether people were being supported to eat in line with their preferences. For example, one person had a clear preference for food from a particular culture, but their records did not capture what they had actually eaten so it was not clear they had had their preferences met, or how much they had eaten.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Visiting healthcare professionals told us they had positive working relationships with the home. They told us referrals were made in a timely manner and they felt their advice was followed.
● People told us they were able to access healthcare services when they needed. People said a GP would visit them and we saw nurses liaising with the GPs throughout our inspection.
● Contact with healthcare professionals were recorded in people's files with notes for staff to follow instructions. However, it was not always clear that this advice was incorporated into people's care plans. For example, one person had been visited by a podiatrist and an optician but there was no record of any actions or advice following these visits. Another person's care file mentioned they did not like to wear their glasses, and their GP had suggested a referral to the optician in October 2018. There was no record the person had been seen by an optician by the time of our inspection in February 2019.

Adapting service, design, decoration to meet people's needs
● The suitability of the home environment was not consistent. Whilst there were some areas that were well presented and followed best practice, other parts of the home were tired. For example, one community for people living with dementia contained a garden lounge and items to interact with, we did not observe people using these.
●The service had received funding to make areas of the home more suitable for people living with dementia. The 'quiet lounges' had been redecorated and themed. We did not see these rooms being used by anyone except for staff updating paperwork throughout our visit.
● The decoration of the service was not always bright and homely. The areas where people spent the majority of their time in were dated and required updating. Some bedrooms also had a tired appearance, with remnants of bluetac left on walls and labels on drawers.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Inadequate:□People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

Ensuring people are well treated and supported; equality and diversity; Respecting and promoting people's privacy, dignity and independence

● During the inspection there were multiple occasions when we saw people were not treated kindly or with respect.

● In one community a person was seen to be in distress and requesting support while in a bathroom with the door open. When staff were alerted their response was to shut the door rather than support the person. It took a further twenty minutes for a different staff member to provide care to this person.

● In another community an inspector saw a person lying on their bedroom floor expressing acute distress. The inspector alerted the nearest nurse who went to get a care worker rather than responding to the person themselves.

● Later in this community a person was sitting in the lounge repeatedly asking for help. There was a staff member in the room who was not responding to this clear request. When the inspector spoke to the person the staff member informed them, loudly, from at least 4 meters away, "They are asking to go to the lounge, but they are in the lounge." The person responded positively to small talk with the inspector which showed their request was more for interaction than relocation. The staff member had failed to recognise this or respond to this person's clear communication in a caring way.

●A member of the inspection team was disorientated by the layout, rather than asking if they wanted help finding their way, a member of staff raised their voice and said from down a hallway "What are you doing there?" The team member felt they had been shouted at. This made us concerned that staff did not always recognise the impact their tone of communication may have on people living with dementia.

●At mealtimes we saw people were wearing clothes protectors across all the communities. We did not see anyone being asked if they wished to wear these. At one mealtime a person accidentally dropped a large part of their meal on the floor. After their plate was cleared they were picking food from the tablecloth. Staff did not respond to this or notice the person appeared to still be hungry, having not been able to eat part of their meal.

●The home supported people with a wide range of cultural backgrounds and religious beliefs. The support people needed to maintain their cultural identity or practice their faith was not recorded. One person told us they wished to attend their place of worship, rather than be visited by a faith representative. They told us they had been told this was not possible. While it was on display when representatives of one faith group visited, it was not easily visible when representatives of other faith groups attended the home.

● Needs assessments and care plans referred to people's significant relationships where these were heterosexual. However, there was no exploration of people's sexual or gender identity as part of the assessment process. This meant there was a risk that people did not feel safe to disclose this information as it was not asked, and the service was not making it clear it was a safe environment to express individual

sexual and gender identities.

The above issues are a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

● People told us their visitors were able to come freely. Visitors confirmed they felt welcome to visit at any time. Care plans recorded when people wished for family members to be involved in supporting them to make decisions about their care.

● Care plans did not consistently reflect people's views about their care. Although care plans contained a section for staff to record "resident preferences and views" these were often completed with a description of their needs rather than their views or preferences.

● People had access to facilities to prepare their own drinks, on one community we observed a person preparing drinks for themselves and making choices independently.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:□People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● Care plans were not personalised and did not provide sufficient detail to ensure people's individual preferences were met. None of the care plans provided details such as water temperature preferences, or product preferences. It was not recorded how often or how people wished for their hair to be washed. Support was described in high level terms, such as "full assistance" or "prompting" without any detail of what this meant for each individual. As agency use was high in some of the units this meant there was a risk people would not receive the support they needed as staff may make assumptions about what "assistance" means when it is not described.

● Records did not show people were receiving care as planned. Two people's care plans showed they wished to have either a full shower or immersive bath once a week. Records showed neither person had a shower or immersive bath for two months. Another person was meant to have a bath once a week but was only having one a month.

● Records of care were extremely limited and described tasks completed. They did not capture people's experience or mood.

● The home employed three activities coordinators who worked a varied pattern of hours to provide activities across the home. However, it was not clear that the activities were suitable or at the request of people who lived in the home. Records of activities showed people did not always engage and were not supported to have alternatives. For example, one person's records showed they either slept or cried throughout activities. There was no indication that alternatives had been offered.

●People and staff told us they felt it was a shame they were not easily able to access the garden and local green spaces. One person said, "There are not enough staff to take me into the garden when I want." Another person said, "There are fewer activities than there used to be." A relatives told us they had never seen activities on offer when they visited. People also told us about activities they would like to do but were not offered.

●We saw people were not always offered opportunities for engagement during the day. In the communal areas of the home we saw people mainly slept in armchairs. In one community staff had promised a "sing along" which did not take place. A ball game was offered but people were not engaging with this and no alternative was attempted.

●Across each of the communities we noticed that music was playing. However, no one was asked what music they wished to hear, and when the CD finished after a short period the same CD was re-started without checking it was what people wanted. In one community the music was played very loudly which prevented conversation. As the activities coordinator was facilitating a session at the same time they had to raise their voice for people to hear what they were saying, it meant the atmosphere felt chaotic.

End of life care and support

●Records about people's wishes for the end of their lives were not clear and in one case this was dangerous.

For this person there was a "do not attempt cardio pulmonary resuscitation" (DNACPR) paper in the front of their file. However, this was invalid as it had not been signed by a healthcare professional and the person's wish to be resuscitated had been recorded. This conflicted with information from their assessment and their discharge prognosis which clearly indicated they were approaching the last stages of their life. The provider told us they would ensure these issues were clarified and the invalid DNACPR was removed from the file.

● Assessments and care plans both contained sections for recording people's wishes regarding their end of life care. However, these were poorly completed in al the files we reviewed. For example, one person's stated, "Needs family support to discuss choices and preferences in relation to the end of her life." None of the other details were completed.

● Across all the care plans reviewed the details regarding how to identify if people may be approaching the last stages of their life were not completed. This had previously been identified by a local authority contract monitoring visit as a concern and the service had been advised to make improvements to how they monitored deteriorating wellbeing.

The above issues around person centred care and end of life support are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● People were informed how to complain. Information about how to raise complaints was on display within each community. People told us they knew how to raise concerns.

● Records relating to complaints were not always accurate. We checked the record and it was not always clear when an investigation had taken place and what the outcome was. We informed the registered manager and they told us that these records had been archived and they would send them to us after the inspection. The registered manager sent us their complaints log. This showed they identified the main themes and tracked what stage the investigation and response was at. However, it was not clear if themes were identified and acted upon.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

RI:Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There were a variety of checks and audits undertaken but these had not consistently addressed areas of concern we found during this inspection. For example, records of medicines audits showed they had picked up and addressed issues such as a lack of opened dates on bottled medicines. Our findings showed this had been addressed but the audits had not identified gaps on MARs. A provider audit had picked up a gap on a MAR for a person's inhaler which was consistent with shortfalls we found. This showed that the actions taken in response to this were not robust enough.
- An audit of infection control had found a strong smell of urine on one community in November 2018 and this had not been properly addressed by the time of this visit. We also found further shortfalls with infection control that had not been identified and addressed through audits.
- Records of cleaning were checked by community managers. These checks had failed to identify the dirty condition of sluice rooms found during the inspection.
- The home had a detailed home improvement plan. However, this had evaluated some areas as complete when our findings were that more work was required. For example, the home improvement plan stated a system was in place for monitoring call bell response times. We asked for call bell audits to be submitted to us but these were not received. Likewise, actions relating to records, wound management and medicines were marked as complete when our findings were that further improvements were required.
- The Registered Manager had been in post for over a year. However, for over six months they had been managing the home without the support of a deputy manager or clinical lead. These positions had now been recruited to, but it was clear the level of oversight and audit had not been sufficient while these posts were unfilled. The deputy manager and clinical lead were still in their induction periods at the point of the inspection so the impact of their support for the registered manager had not yet taken effect.
- The provider and commissioning local authorities had all completed quality assurance visits to the home. Over the course of the last six months these monitoring visits had consistently identified issues with the quality and consistency of care plans, records and activities offered. Despite being aware of these issues the actions in place had not been effective in achieving the levels of improvement required.
- We requested additional information regarding call bell monitoring and training at the end of the inspection. Although the registered manager had told us they completed audits, the provider told us these were daily checks and there was no record to show call bell responses were monitored or checked.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There was an annual survey carried out and the provider analysed the results. The feedback for the most survey was positive and the registered manager monitored online feedback in order to identify any areas for improvement. We noted online feedback had been positive.

● Systems were in place to enable people and relatives to give feedback. An electronic feedback device was available within the reception area of the home. The registered manager told us they analysed this feedback as well as regularly seeking the views of people and relatives at meetings.

● People and relatives took part in meetings to discuss the service and provide an opportunity to make suggestions or give feedback.

Continuous learning and improving care

● The registered manager kept a record of accidents and incidents and these were monitored by the provider to identify patterns and trends. We saw records of meetings at a provider level which were used to discuss risks and share learning from incidents. For example, a recent meeting had discussed moving and handling and equipment in response to an issue raised at another service.

Working in partnership with others

● Visiting healthcare professionals told us they had developed positive working relationships with the service.

● The limited capacity of the management team had had an impact on the service's ability to demonstrate their partnership working with other organisations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care plans lacked detail and clarity about people's needs and preferences. Records did not show people received their care as planned. Regulation 9(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People were not always treated with respect and their dignity was not always maintained. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The service had not followed the principles of the Mental Capacity Act. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks to people were not clearly assessed or mitigated. Medicines were not always managed in a safe way. Regulation 12(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care Treatment of disease, disorder or injury	governance Governance arrangements had not operated effectively to improve the quality and safety of the service. Regulation 17(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received the training or support they needed to perform their roles. Regulation 18(2)